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NAVAL MEDICAL SURVEILLANCE REPORT

N M S R

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Data in the NMSR are provisional, based on reports and other sources of data available to the Navy Environmental Health Center. Notifiable conditions are classified by date of report. Only cases submitted as confirmed are included.

FROM THE PREVENTIVE MEDICINE DIRECTOR

CAPT Bruce K. Bohnker, MC, USN(FS)

As I take over as the new Director of Preventive Medicine at the Navy Environmental Health Center, I want to thank CDR Bob Rendin for his efforts and accomplishments here. As always, he leads the way, moving across the river to the Navy Medical Center, Portsmouth, where he will be the Preventive Medicine Department Head. The rest of NEHC is scheduled to move to our new spaces on that compound in December. Look for new telephone numbers in our next edition, though email addresses should remain the same. I also wanted to welcome CAPT Jim McGinnis into the directorate, where he will be assisting me as well as being the director for the Workshop next year. With this year's workshop in San Diego in May, and next year's workshop in Chesapeake in the March timeframe, he will be spinning up quickly. He will be replacing CDR Brian Murphy, though CDR Murphy will be around until about November, when he will move across the country to San Diego, reporting to the Naval Health Research Center. We also get to bid "fair winds and following seas" to CAPT Larry Betts in Occupational and Environmental Medicine who will be retiring in July 2001 after a long and distinguished Naval career.

As the worldwide NEHC command works through the strategic planning process, command metrics have come to the forefront. For the Preventive Medicine Directorate, much of the data for those metrics will be obtained from the Naval Disease Reporting System (NDRS). Quarterly reporting on the following PM areas are included in the command metrics:

- Vector-borne Disease Occurrence Navy and Marine Corps for Malaria, Dengue, Lyme Disease, Hantavirus Infection, Rocky Mountain Spotted Fever (RMSF) and Japanese Encephalitis.
- Disease Non-battle Injury (DNBI) rates (are currently available only from FIFTHFLEET, but we would like to expand this reporting).
- Rates of gonorrhea, chlamydia, and syphilis for Active Duty (AD) Navy and Marine Corps.
- Rate of Active Tuberculosis for AD Navy and Marine Corps.

Thus, accurate and complete reporting of these (as well as all reportable diseases) remains critical. We at NEHC PM rely on the effort and support of the medical department personnel treating the Sailors and Marines, and generating the inputs for our PM command metrics. Thanks.

Naval Medical Surveillance Report

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Views and opinions expressed are not necessarily those of the Department of the Navy

DEPLOYMENT MEDICAL SURVEILLANCE

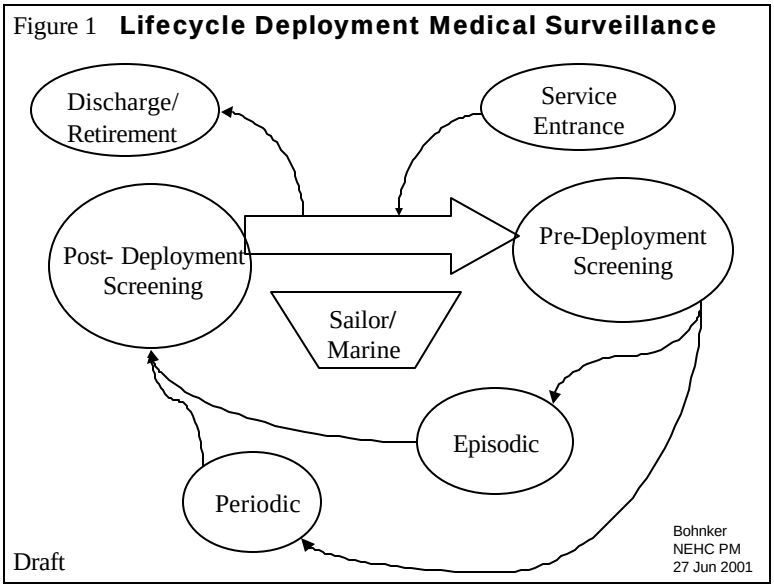
CAPT Bruce K. Bohnker, MC, USN(FS)

One of my major responsibilities as new Director for Preventive Medicine at NEHC will involve Deployment Medical Surveillance (DMS), so I wanted to provide some brief background and concepts. The current DMS process is evolving and expanding over time, and not fully matured. The requirements for DMS were established by the United States Congress after the Desert Storm experience, and the Department of Defense has provided extensive guidance. NEHC was designated the Navy Medicine program manager for Deployment Medical Surveillance in 1998. The NEHC DMS website (http://www-nehc.med.navy.mil/prevmed/epi/depsurv.htm) provides background information and downloads. The NEHC Technical Manual 6490.1 (September 2000) is an excellent resource and can be found at website http://www-nehc.med.navy.mil/prevmed/pubstat.htm.

A basic precept in DMS comes from the final word "surveillance," which suggests data flow, tracking and analysis. While the focus is on deployment, such surveillance requires baseline data for comparison, including pre-service medical exam and inter-deployment data. It also implies ongoing monitoring of current reporting and reach-back after discharge or retirement, thus the concept of lifecycle deployment medical surveillance. The accompanying "draft" figures provide some simplified graphics for lifecycle deployment medical surveillance for our Sailors and Marines, who should always be at the center of our efforts.

Figure 1 presents an overall concept of DMS, beginning with service entrance, through pre-deployment screening, episodic and periodic reporting, post-deployment screening, and finally with discharge/retirement. The large arrow is an important feature, since our Sailors and Marines may simultaneously be completing post-deployment screening and pre-deployment screening due to high operational tempo and transfers. That line also incorporates a host of other occupational and service-specific monitoring processes. Figure 2 presents "episodic" reporting for DMS, per BUMEDINST 6220.12A using the Medical Event Report (MER) to report specific medical conditions. The MERs are submitted through the Naval Disease Reporting System (NDRS), which is a computer based program available through the website. The figure illustrates clinic/Medical Treatment Facility (MTF)-based care, though ship sickbays and battalion aid stations are generally equivalent. This reporting includes conditions that are considered "Tri-Service Reportable Diseases," which are forwarded by NEHC to the Army Medical Surveillance Activity (AMSA) in Washington, DC.

Figure 1 **Lifecycle Deployment Medical Surveillance**



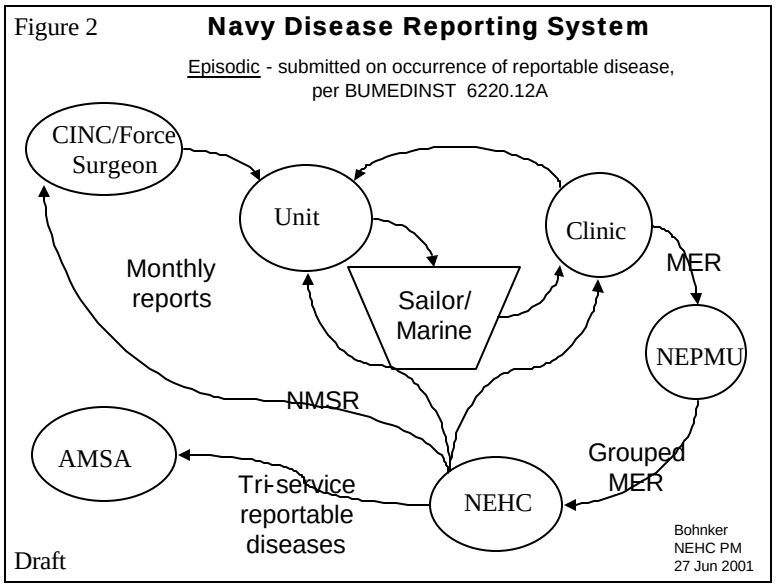
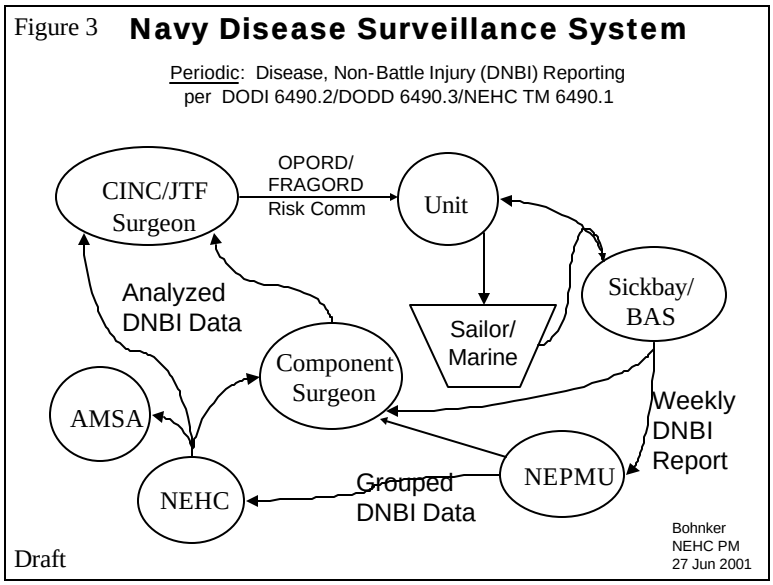


Figure 3 illustrates "periodic" monitoring through Disease Non-Battle Injury (DNBI) reporting. DNBI reporting for the Navy remains an emerging process except for U.S. Naval Forces Central Command/Fifth Fleet, where such reporting has been mandated. DNBI surveillance involves weekly reporting using syndromic criteria developed by the Joint Chiefs of Staff, and allows commanders and their medical staffs to assess the "vital signs" of the units. The periodic DNBI reporting is operationally based at present, though expanding that capability is a longer term goal.



Two points serve to close this simplified and brief introduction into current DMS concepts. First, information flow back to the medical personnel at the units and staffs is critical, and an area that warrants more emphasis. Those personnel require accurate and timely access to appropriately analyzed information to allow them to provide risk assessment and risk communication to their commanders and supported personnel. And finally, the focus of current and future DMS must be on maintaining the health and well being of the Sailors and Marines, upon whose shoulders the defense of this great Nation rests.

COMMUNICABLE DISEASE

HIV SEROCONVERSION AMONG ACTIVE DUTY SAILORS AND MARINES, 1985-2000

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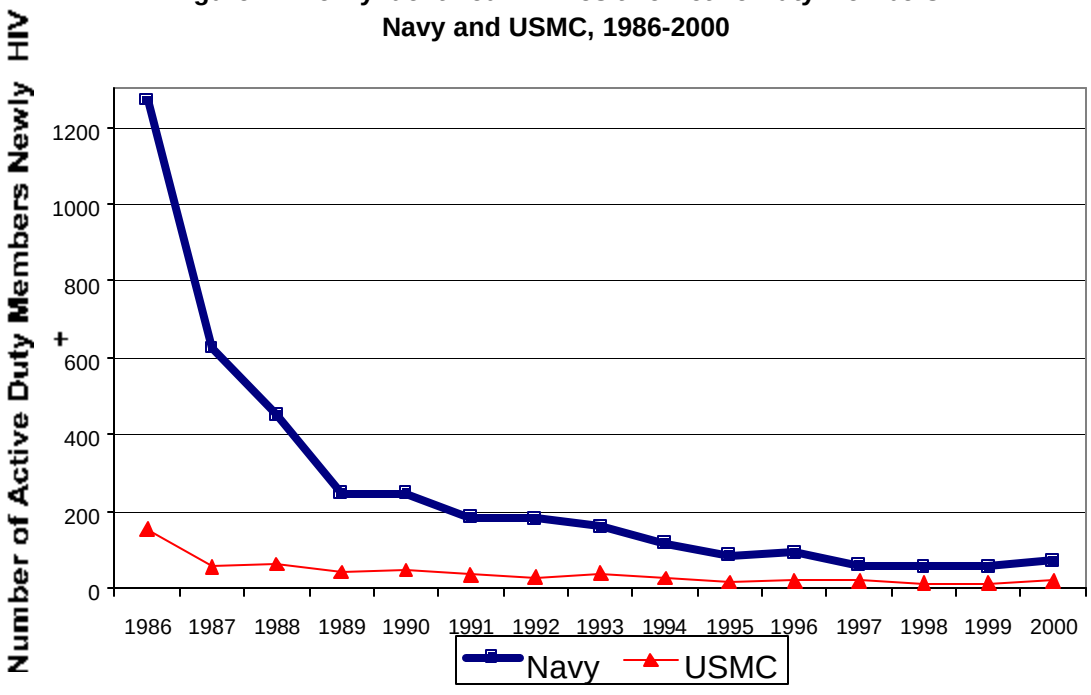
Navy Environmental Health Center, Norfolk VA

Human Immunodeficiency Virus (HIV) testing of all active duty Sailors and Marines began in late 1985. The total force screening program goal was to test all active duty members at least once within the first 2 years, and again during the next 2 years. Tests are performed in accordance with Department of Navy policy.[1] Data on newly identified cases of HIV infection among active duty Sailors and Marines from 1986-2000 are shown in Figure 1. Since 1985, there have been 4,680 documented cases of HIV infection among active duty Sailors and Marines.[2] Figure 1 does not plot the HIV positive members identified in late 1985 when testing first began (126 Navy, 13 USMC). Note that Figure 1 plots newly identified infections, not necessarily newly acquired infections. The distinction is important, particularly in the earlier years, where the number of positive members is more an indication of pre-existing plus newly acquired HIV infection (prevalence). Predictably, the first few years of testing identified higher numbers of HIV positive members. Since all new accessions into the Navy and USMC have been screened for HIV infection (and people who are positive are excluded), the number of HIV infections identified in later years is more an indication of newly acquired infections (annual incidence).

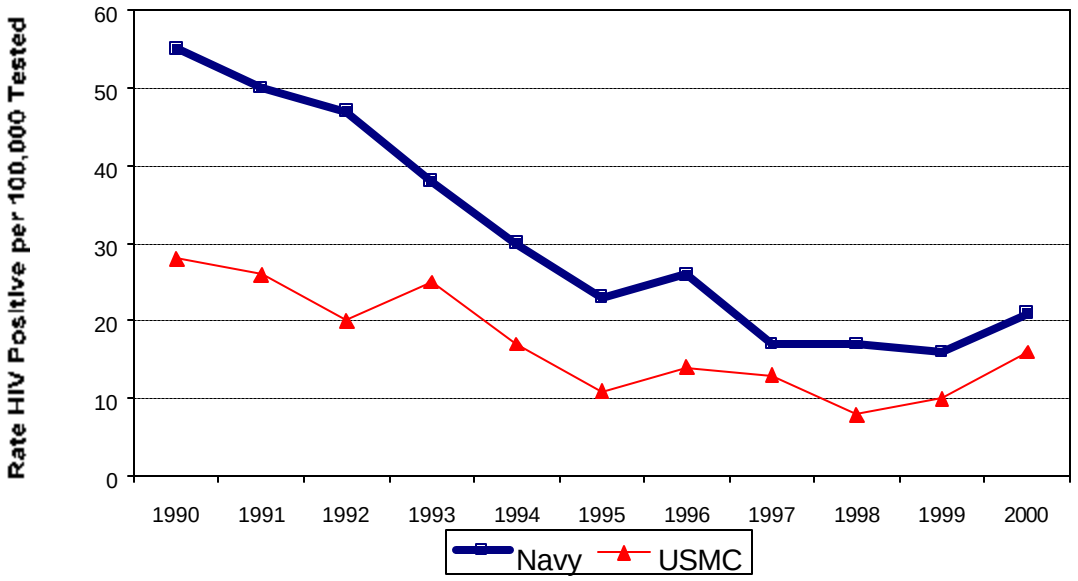
Figure 1: Newly Identified HIV Positive Active Duty Members Navy and USMC, 1986-2000



During calendar year 2000, 348,686 active duty Sailors, and 139,809 active duty Marines were tested for HIV antibodies. Of these, 73 Sailors and 22 Marines were newly identified as HIV positive. HIV seroconversion rates (cases per 100,000 members tested) among active duty Sailors and Marines from 1990-2000 are shown in Figure 2. These rates increased in calendar year 2000.

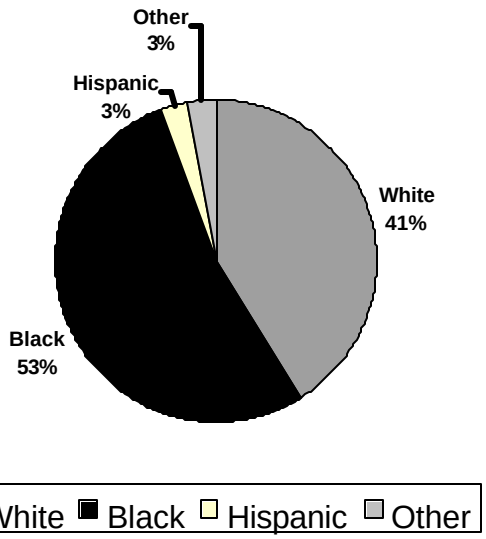
Among active duty Sailors, the rate rose from 16 to 21. Among Marines, the rate rose from 10 to 16. While higher than the 1999 rates, the Navy and USMC rates remained below the 1990-1999 means of 31 and 17, respectively, and do not represent any statistically significant change from the 1999 rates. They do demonstrate that the HIV epidemic continues to affect the active duty force.

Figure 2: HIV Seroconversion Rates per 100,000 Tested Navy and USMC, 1990-2000



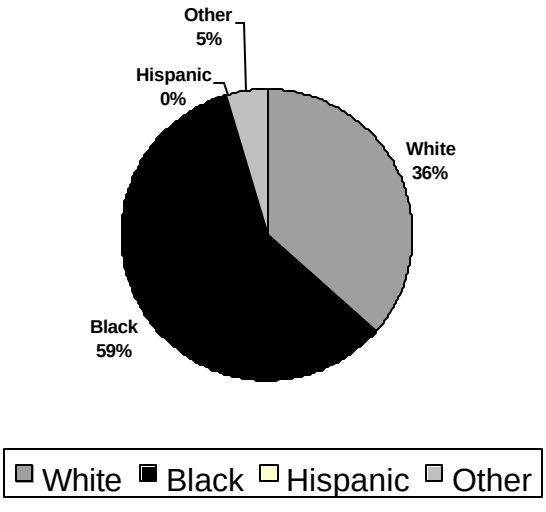
Racial groupings of the 73 active duty Sailors newly identified as HIV positive in 2000 are shown in Figure 3. Among these 73 Sailors, 53% were black, 41% white, 3% Hispanic, and 3% were other races. Black Sailors were disproportionately affected. As of 31 December 2000, 19% of active duty Sailors were black[3]. A similar, though even greater disproportionate racial distribution is seen in the general United States population where black Americans accounted for 54% of the estimated 40,000 new HIV infections in 2000, though black Americans comprised only 13% of the general population.[4] Differences in gender between the U.S. general public and the Navy are worth noting. In the Navy, 4% of new HIV infections in 2000 were among women, while this figure was 30% nationally. However, while about 50% of the U.S. population aged 18-45 was female, only 15% of Sailors were women.

Figure 3: Newly Identified HIV Positive Active Duty Sailors, by Race
Jan-Dec 2000 (n=73)



Racial groupings of the 22 active duty Marines newly identified as HIV positive in 2000 are shown in Figure 4. Among these Marines, 59% were black, 36% white, 5% were other races (0% Hispanic). All HIV positive Marines were male.
(Con't. on page 10)

Figure 4: Newly Identified HIV Positive Marines, by Race
Jan-Dec 200 (n=22)



NAVAL DISEASE REPORTING SYSTEM (NDRS)

SUMMARY OF 2001 DATA

Tables 1 and 2 display the Medical Event Reports (MERs) received at Navy Environmental Health Center (NEHC) as of 30 Jun 2001. Interested readers may calculate rates by dividing the frequencies by estimated mid-year strength of 370,068 for USN and 171,283 for USMC as of April 2001. (Table 1 shows active duty only. Table 2 shows non active duty beneficiaries.)

Table 1. Reportable Medical Events, Combined Navy & Marine Corps Active Duty, Case Frequencies, 01 Jan – 30 Jun, 2001

Disease	Total	USN	USMC	Disease	Total	USN	USMC
Amebiasis*	2	2	0	Lyme Disease	2	2	0
Anthrax*	0	0	0	Malaria	1	1	0
Biological warfare agent exposure	0	0	0	Measles*	0	0	0
Bites, rabies vaccine & human rabies immune	0	0	0	Meningitis (aseptic, viral)	3	3	0
Bites, venomous animal	1	0	1	Meningitis (bacterial other than Meningococcus)	1	1	0
Botulism*	2	2	0	Meningococcal disease*	1	1	0
Brucellosis	0	0	0	Mumps	0	0	0
Campylobacteriosis*	1	1	3	Occupational exposure to blood borne pathogens	0	0	0
Carbon Monoxide poisoning*	0	0	0	Onchocerciasis	0	0	0
Chemical warfare agent exposure	0	0	0	Pertussis*	0	0	0
Chlamydia	438	329	109	Plague*	0	0	0
Cholera	0	0	0	Pneumococcal pneumonia	4	0	4
Coccidioidomycosis	1	0	1	Poliomyelitis*	0	0	0
Cold injuries	0	0	0	Psittacosis (Ornithosis)	0	0	0
Cryptosporidiosis*	0	0	0	Q Fever*	0	0	0
Cyclospora*	0	0	0	Rabies, clinical human*	0	0	0
Dengue fever*	0	0	0	Relapsing fever	0	0	0
Diphtheria	0	0	0	Rift Valley fever	0	0	0
E. Coli 0157:H7 infection*	0	0	0	Rocky-Mountain Spotted Fever	3	3	0
Ehrlichiosis	0	0	0	Rubella*	0	0	0
Encephalitis*	0	0	0	Salmonellosis*	0	0	0
Filariasis	0	0	0	Schistosomiasis	0	0	0
Giardiasis	2	2	0	Shigellosis*	0	0	0
Gonorrhea	162	133	29	Smallpox*	0	0	0
Haemophilus influenza, type b	1	0	1	Streptococcal disease, Group A	0	0	0
Hantavirus infection*	0	0	0	Syphilis	2	2	0
Heat injuries	1	0	1	Tetanus	1	1	0
Hemorrhagic fever*	0	0	0	Toxic shock syndrome	0	0	0
Hepatitis, A (acute, symptomatic only)	0	0	0	Trichinosis	0	0	0
Hepatitis, B (acute, symptomatic only)	2	2	0	Trypanosomiasis	0	0	0
Hepatitis, C (acute, symptomatic only)	1	1	0	Tuberculosis, pulmonary active*	1	1	0
Influenza (confirmed)	20	0	20	Tularemia*	0	0	0
Lead poisoning	0	0	0	Typhoid fever*	0	0	0
Legionellosis*	0	0	0	Typhus*	0	0	0
Leishmaniasis	0	0	0	Urethritis (non gonococcal)	45	14	31
Leprosy (Hansen's disease)	0	0	0	Varicella	0	0	0
Leptospirosis*	0	0	0	Yellow fever	0	0	0
Listeriosis	0	0	0				

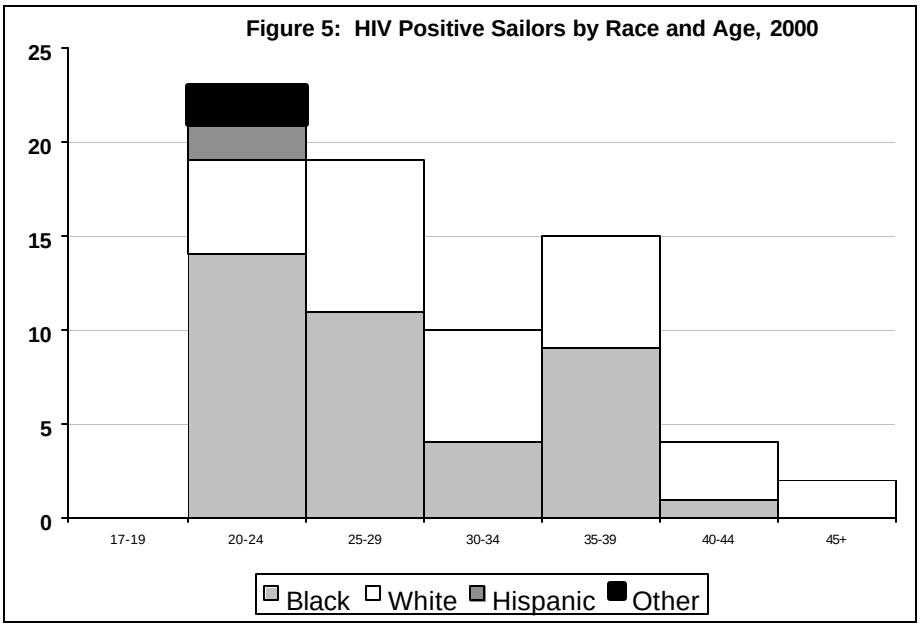
***Reportable within 24 hours**

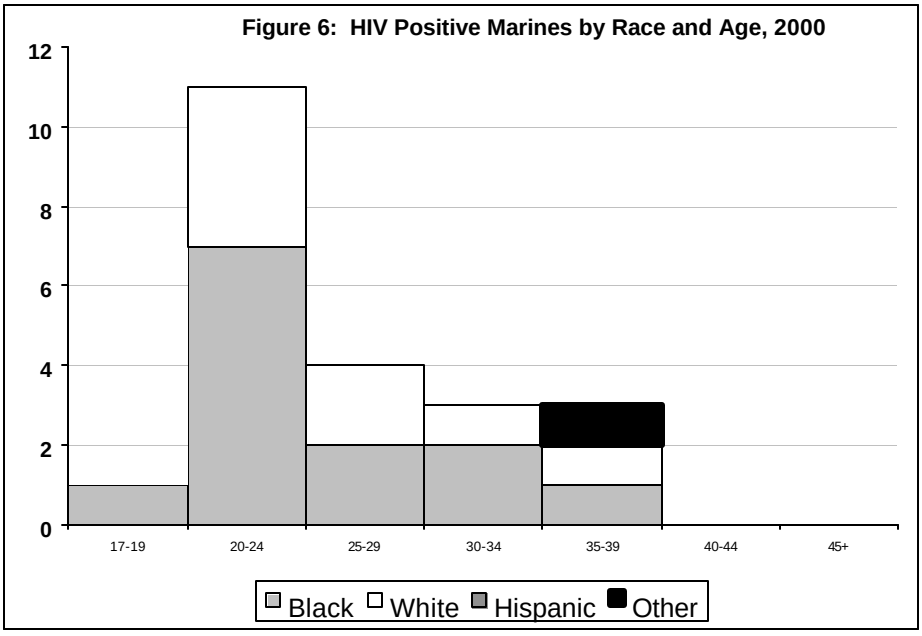
Table 2. Reportable Medical Events, Combined Navy & Marine Corps Beneficiaries, Case Frequencies, 1 Jan - 30 Jun, 2001

Disease	Total	USN	USMC	Disease	Total	USN	USMC
Amebiasis*	0	0	0	Lyme Disease	9	4	5
Anthrax*	0	0	0	Malaria	3	1	2
Biological warfare agent exposure	0	0	0	Measles*	0	0	0
Bites, rabies vaccine & human rabies immune	42	41	1	Meningitis (aseptic, viral)	26	16	10
Bites, venomous animal	0	0	4	Meningitis (bacterial other than Meningococcus)	12	10	2
Botulism*	0	0	0	Meningococcal disease*	4	4	0
Brucellosis	0	0	0	Mumps	1	1	0
Campylobacteriosis*	17	15	2	Occupational exposure to blood borne pathogens	0	0	0
Carbon Monoxide poisoning*	0	0	0	Onchocerciasis	0	0	0
Chemical warfare agent exposure	0	0	0	Pertussis*	2	2	0
Chlamydia	484	323	161	Plague*	0	0	0
Cholera	0	0	0	Pneumococcal pneumonia	7	6	1
Coccidioidomycosis	7	6	1	Poliomyelitis	0	0	0
Cold injuries	0	0	0	Psittacosis (Ornithosis)	0	0	0
Cryptosporidiosis*	0	0	0	Q Fever*	0	0	0
Cyclospora*	0	0	0	Rabies, clinical human*	0	0	0
Dengue fever*	0	0	0	Relapsing fever	0	0	0
Diphtheria	0	0	0	Rift Valley fever	0	0	0
E. Coli 0157:H7 infection*	1	1	0	Rocky-Mountain Spotted Fever	0	0	0
Ehrlichiosis	0	0	0	Rubella*	3	3	0
Encephalitis*	0	1	0	Salmonellosis*	50	43	7
Filariasis	0	0	0	Schistosomiasis	1	1	0
Giardiasis	15	15	0	Shigellosis*	3	3	0
Gonorrhea	85	67	18	Smallpox*	0	0	0
Haemophilus influenza, type b	12	10	2	Streptococcal disease, Group A	12	8	4
Hantavirus infection*	0	0	0	Syphilis	4	4	0
Heat injuries	0	0	0	Tetanus	0	0	0
Hemorrhagic fever*	0	0	0	Toxic shock syndrome	0	0	0
Hepatitis, A (acute, symptomatic only)	3	2	1	Trichinosis	0	0	0
Hepatitis, B (acute, symptomatic only)	3	2	1	Trypanosomiasis	3	2	1
Hepatitis, C (acute, symptomatic only)	1	0	1	Tuberculosis, pulmonary active*	14	12	2
Influenza (confirmed)	1	1	0	Tularemia*	0	0	0
Lead poisoning	1	1	0	Typhoid fever*	1	1	0
Legionellosis*	0	1	0	Typhus*	0	0	0
Leishmaniasis	0	0	0	Urethritis (non gonococcal)	0	0	0
Leprosy (Hansen's disease)	0	0	0	Varicella	0	0	0
Leptospirosis*	1	1	0	Yellow fever*	0	0	0
Listeriosis	1	1	0				

***Reportable within 24 hours**

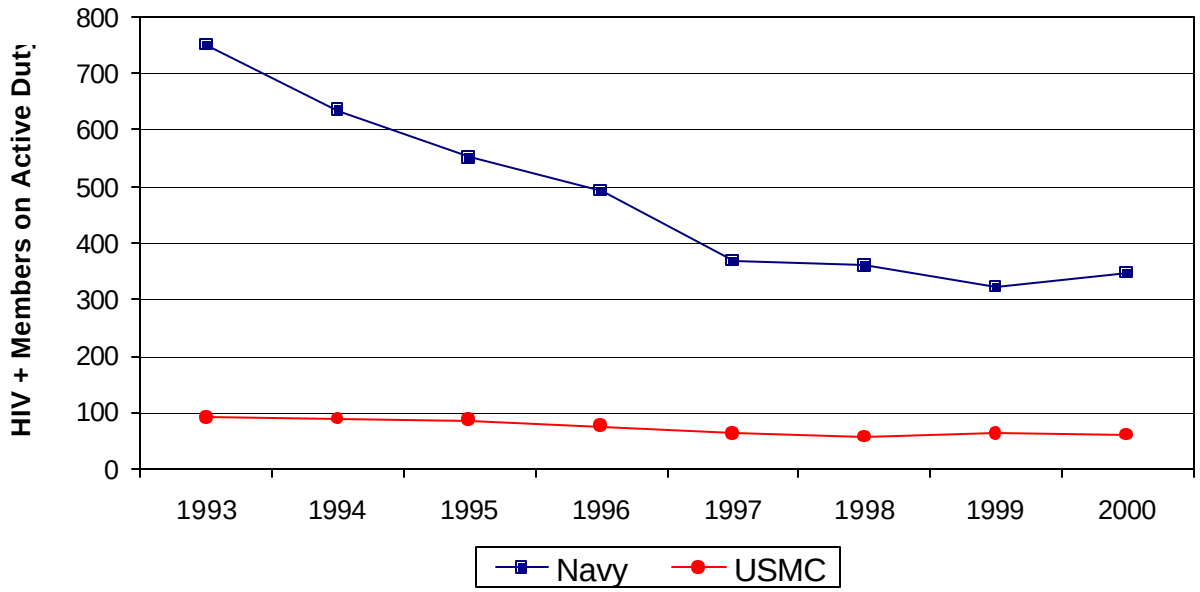
(Con't. from page 7)
Age and racial groupings of the 73 newly identified HIV positive active duty Sailors and Marines are shown in Figures 5 and 6, respectively. The largest age group of newly infected Sailors was the 20-24 year old group (23 of 73; 31.5%). While most newly infected Sailors were under age 29 (about 58%), it is noteworthy that many (42%) were older than this. In fact, among white HIV positive Sailors, more were over 30 years old than under 30 (17 vs. 13; 57%). The largest age group of newly infected Marines was the 20-24 year old group (11 of 22; 50%). Most newly infected Marines were under age 29 (73%).





The numbers of HIV positive Sailors and Marines on active duty by year, 1993-2000 are shown in Figure 7. HIV positive members are retained on active duty provided they show no evidence of clinical illness or immunologic or neurologic impairment related to their HIV infection.[5] These members are assigned only within the United States (including Hawaii, Alaska, and Puerto Rico) to a unit not normally programmed for deployment, and one which is within 300 miles of a Naval Medical Treatment Facility. Combination therapies to improve the health of HIV positive members may have contributed to the "leveling off" of the numbers seen in 1997-98.

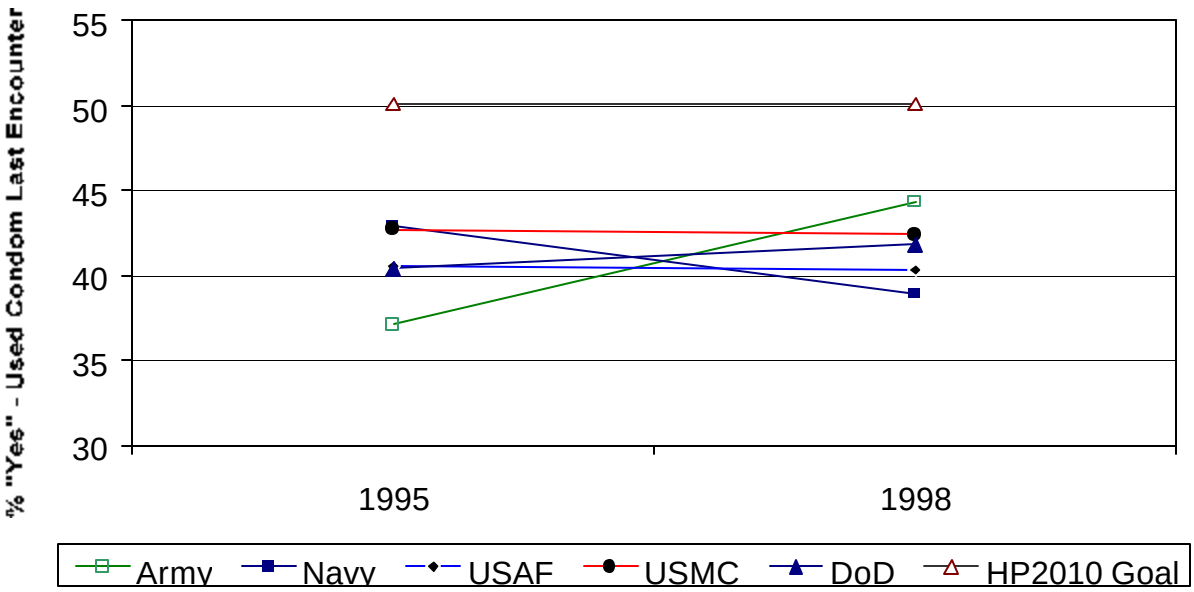
Figure 7: HIV Positive Sailors and Marines on Active Duty End of Calendar Year 1993-2000



These therapies might actually increase the prevalence of HIV positive Sailors and Marines on active duty, as is now seen in 2000. Self-reported condom use at last sexual encounter by unmarried active duty military personnel in 1995 and 1998 is shown in Figure 8. These data indicate that use of a condom at last sexual encounter among sexually active unmarried Sailors dropped from 42.9% to 38.9% (lowest in DoD) from 1995 to 1998.[6] The Department of Health and Human Services Healthy People 2010 goal and the DoD goal for condom use at last sexual encounter is 50% or more. For people who decide to have sex outside a monogamous relationship, the correct and consistent use of latex condoms during sexual intercourse–vaginal, anal, or oral–can greatly reduce a person' s risk of acquiring or transmitting most sexually transmitted diseases (STDs), including HIV infection, gonorrhea, chlamydia, trichomonas, human papilloma virus (HPV), and hepatitis B.[7]

Reducing the incidence of HIV among Sailors and Marines is one of the goals of the NEHC Sexual Health and Responsibility Program (SHARP) (DSN 253-5566). SHARP training and educational products may be reviewed on-line at www-nehc.med.navy.mil/hp/sharp

Figure 8: Condom Use Among Unmarried Active Duty Members of the Military, 1995 and 1998



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7. Centers for Disease Control and Prevention. Condoms and their use in preventing HIV infection and other STDs. CDC, Atlanta, GA. September 1999

INFORMATION ABOUT DMED

LCDR(S) Jeff Brady, MC, USN
Navy Liaison, Defense Medical Surveillance System
Army Medical Surveillance Activity

DMED provides remote access to a subset of data contained within the Defense Medical Surveillance System (DMSS). DMSS contains up-to-date and historical data on diseases and medical events (e.g., hospitalizations, ambulatory visits, reportable diseases, etc.) and longitudinal data relevant to personnel characteristics and deployments experience for all active duty and reserve component service members.

The DMED application provides a user-friendly interface through which users may perform queries regarding disease and injury rates and relative burdens of disease in active duty populations. Through the use of client-server technologies and database optimization, DMED users have unprecedented capabilities to access Tri-Service epidemiologic data and to submit tailored queries that are responded to in a timely (seconds) and efficient manner.

DMED is maintained and distributed by the Army Medical Surveillance Activity (AMSA), Directorate of Epidemiology and Disease Surveillance, US Army Center for Health Promotion and Preventive Medicine (USACHPPM).

For more information about DMED, including how to download the application software, visit the AMSA web site at http://amsa.army.mil. Then, choose DMED from the left column of choices, and follow the directions if you wish to download the software.

ANTHRAX VACCINE IMMUNIZATION PROGRAM (AVIP)

ANTHRAX VACCINE ADVERSE EVENT REPORTING SYSTEM (VAERS) UPDATE

Table 1 displays the total Anthrax VAERS reports submitted through 30 Jun 2001. The source of this data is the Army Medical Surveillance Activity (AMSA).

Table 1. Cumulative Data (date 28 Aug 1998 - 30 Jun 2001)

Service	VAERS Report		Classification				
	Required		Local Reaction			Systemic Reaction	Cum. Totals
	Yes	No	Mild	Moderate	Severe		
USA	13	104	14	23	13	67	117
USN	4	69	6	7	8	52	73
USAF	30	416	31	48	30	337	446
USMC	2	26	1	6	2	19	28
USCG	0	1	0	1	0	0	1
Excludes 4 ODS/DS VAERS Reports on Anthrax and Non-DoD Reports							

THE USDOD'S PROGRAM FOR HIV/AIDS REDUCTION IN AFRICAN MILITARIES

LCDR Mark Malakooti, MC, USN

A U.S. Department of Defense (DoD) program was started in 2000 to assist African country militaries with prevention and control of HIV/AIDS. At first it was called the DoD-LIFE Initiative (Leadership and Investment in Fighting an Epidemic), and the Naval Health Research Center (NHRC) was chosen as the U.S. DoD Executive Agent. The title is now simply the DoD HIV/AIDS Prevention Program; the Executive Agent reports to the Deputy Assistant Secretary of Defense (DASD) for African Affairs via BUMED and normal chain of command. As part of the overall U.S. effort to fight the pandemic of HIV/AIDS in Africa, DoD was tasked to work with the militaries of selected countries to reduce the spread of HIV among military personnel. A budget of $10 million was provided through September 2002, and a ranked list of priority countries was provided by the Department of State. This list took into consideration any history of important defense relationships with the U.S., strategic priorities, international defense policy, and other contingency interests. First priority countries were Nigeria, South Africa, Ethiopia, Botswana, and Senegal; in addition, Angola was included because HIV programs may help leverage a new defense relationship. The second group countries are Kenya, Benin, Mali, Malawi, Ghana, Uganda, Rwanda, Zimbabwe, and Eritrea; third group are Namibia, Gabon, Mozambique, Cote d' Ivoire, Tanzania, and Cameroon; fourth, Guinea-Conakry, Zambia, Congo-Brazzaville, Democratic Republic of the Congo (DROC), Niger, Djibouti, Mauritius, and Burundi; and fifth, Madagascar, Seychelles, Comoros, Mauritania, Equatorial Guinea, Guinea-Bissau, Togo, Gambia, Cape Verde Islands, Sao Tome, Central African Republic, Liberia, and Burkina-Faso. The fourth and fifth groups are countries that will receive support as budget resources permit. The general approach to each country involves a situational assessment, intervention plan and budget coordination, and close follow-up. The U.S. DoD team, while led and coordinated out of NHRC, is a joint-service team of volunteers who expressed interest in working with the program.

A good example of how countries are tackled is the recent trip to Kenya by two team members, one each from NEHC and NHRC. Travel and scheduling of meetings in-country were coordinated through the cognizant Commander in Chief, and the Defense Liaison Office in the U.S. Embassy in Nairobi. A series of meetings were held at the Kenyan DoD (KDOD) headquarters, involving their Surgeon-General; the head of KDOD military public health and HIV programs; the leaders of Kenyan Army and Air Force medicine; a civilian Kenyan expert in HIV/AIDS who coordinated with the KDOD to develop their prevention proposal; the head of the U.S. Centers for Disease Control program in Kenya; the Commander of the U.S. Army research laboratory in Kenya; the U.S. Embassy military liaison officers; and the two members of the U.S. DoD HIV/AIDS prevention team. After general discussion of the current situation in their military and the status of their program, the new KDOD proposal for HIV/AIDS prevention and control was presented and discussed in detail; the proposed budget included their requested/projected contributions from U.S. DoD, CDC, and the KDOD.

The proposal and budget were then taken back to the U.S. DoD program management office, where they will be examined in further detail and the determination made as to which parts of the plan will be supported and funded. The KDOD will then be informed of the amount of money available for their program, and will hopefully proceed to implement their prevention strategies as soon as possible.

By law, the U.S. DoD HIV/AIDS Prevention Program cannot simply transfer funds to the KDOD or other militaries. Funding support is provided via actual resources and materials, which are specifically requested by African militaries and are required in order to implement their HIV/AIDS prevention action plans. Follow-up activities include ongoing assistance with program implementation, maintenance, adaptation, evaluation, and budgetary oversight to ensure that funds are being spent and resources used appropriately.

As of June 2001, almost all the countries listed above in priority groups 1 and 2 have had a needs assessment done, military HIV/AIDS prevention plan analyzed, and resource assistance either ongoing or commencing. More countries have needs assessments planned before the end of 2001, and in addition to funding the African military programs, the U.S. DoD HIV/AIDS Prevention Program will review and fund relevant projects proposed by Non-government Organizations (NGOs) and other groups. Cooperative work will continue with other U.S. Government programs (e.g. USAID, CDC), NGOs, and United Nations agencies. Figure 1 through 3 are included to illustrate the scope of the HIV/AIDS pandemic in Africa.

Figure 1

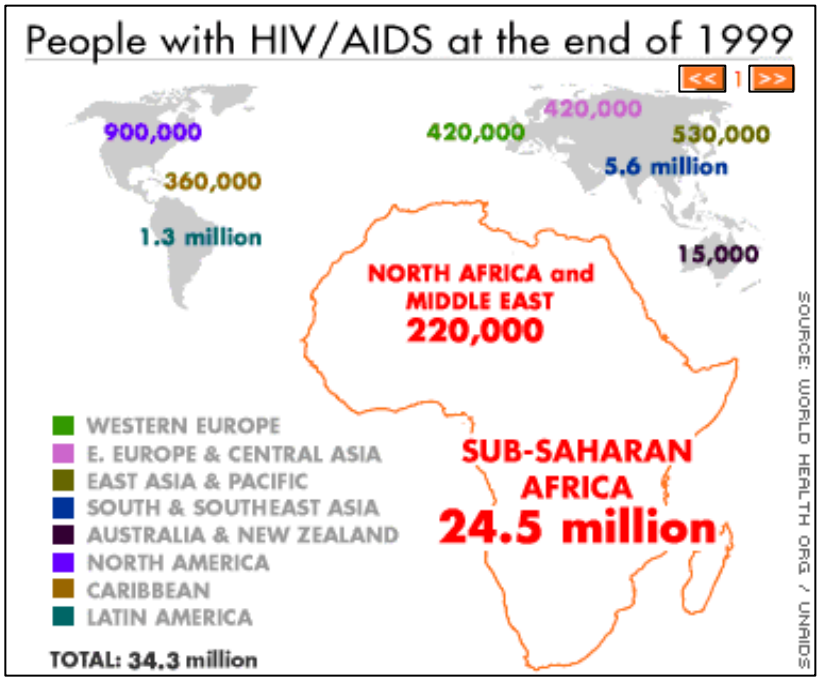


Figure 2

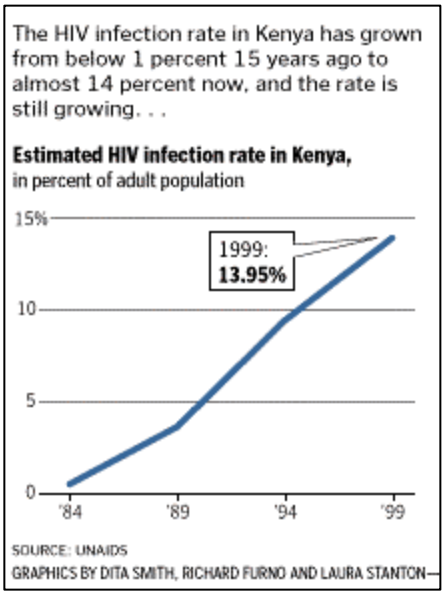
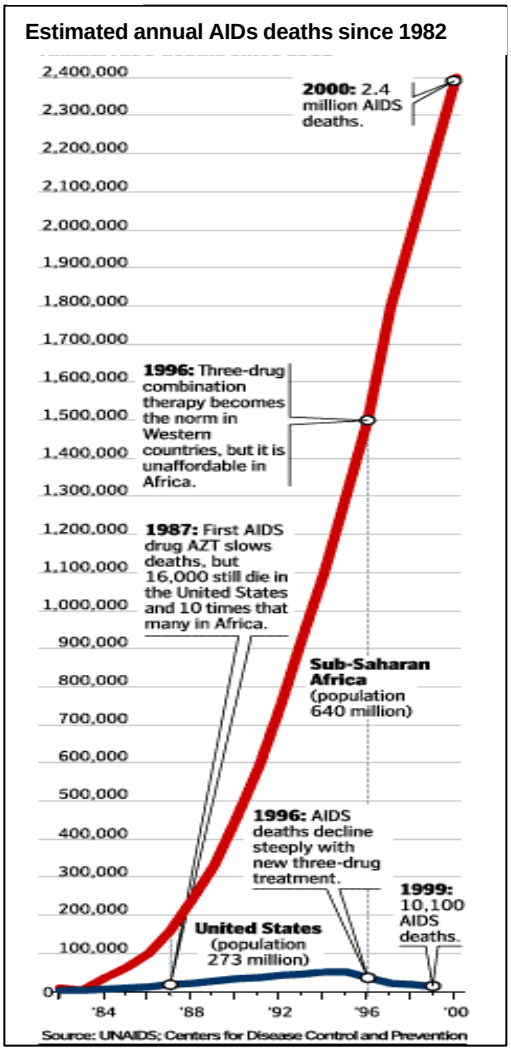


Figure 3



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